

FILED FEB 3 1950

## STANDARD CERTIFICATE OF DEATH

State File No. 2755

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 696	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City		4350	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4359 Taft Ave.				d. STREET ADDRESS (If rural, give location) 7415 Carleton Ave.			
3. NAME OF DECEASED (Type or Print)		a. (First) Evengeline		b. (Middle) F.		c. (Last) Lyon	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Dec. 28, 1855	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. Bradford, N. Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Aaron Fulkerson		13b. MOTHER'S MAIDEN NAME Sarah Booth		14. NAME OF HUSBAND OR WIFE Walter E. Lyon.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Leslie W. Lyon, 7415 Carleton Ave.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Arterio Sclerosis</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <i>Senile Dementia</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i> <i>5 yrs</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>4500</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 1, 1949</i> to <i>Jan 23, 1950</i> , that I last saw the deceased alive on <i>Jan 23</i> , and that death occurred at <i>7:27</i> m. from the causes and on the date stated above.							
23a. SIGNATURE (Doctor or title) <i>W. A. Volpert, M.D.</i>		23b. ADDRESS <i>4124 Gravois</i>		23c. DATE SIGNED <i>1/23/50</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE <i>1/23/50</i>		24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. JAN 23 1950		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wagoner Mortuary, 4161 Lindell Blv.			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

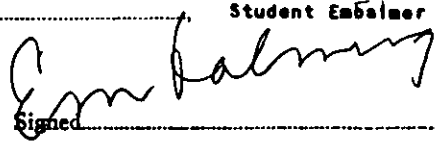
Dr. W. R. ...  
1724 ...

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed    
Student Embalmer No. ....

Licensed Embalmer No. ....

P. O. Address .....

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.